

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be reimbursement for dates of service 7-2-01, 7-3-01, 7-5-01, 7-9-01 and 7-10-01.
- b. The request was received on 6-14-02.

II. EXHIBITS

1. Requestor, Exhibit I:
 - a. TWCC 60 and Letter Requesting Dispute Resolution
 - b. HCFAs
 - c. EOBs
 - d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit II:
 - a. TWCC 60 and Response to a Request for Dispute Resolution
 - b. HCFAs
 - c. EOBs
 - d. Example EOBs
 - e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
3. The Commission requested two copies of additional documentation via a Fee Letter (MR 116) that was mailed to the Requestor on 7-11-02. No response to the request was noted in the dispute packet from Provider. Therefore, the Commission could not forward any additional documentation to the Respondent per Rule 133.307 (g) (4). The Respondent's three (3) day response is reflected in Exhibit II of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 6-14-02:

"Because there is no set fee guideline for chronic pain management in the 1996 TWCC Medical Fee Guidelines, we feel that the \$180.00 per hour that is billed by (Provider) is fair and reasonable. Our program is billed under 97799 CP, as unlisted physical medicine/rehabilitation service or procedure. I have also enclosed copies of other Insurance Carrier's EOB's reflecting their payment of our billed hourly rate of \$180.00 per hour without reduction. The (Provider) hires master level therapists to perform the behavioral component as well as contracts with competent providers to provide the

physical therapy component to make this a true multi-disciplinary program.”

2. Respondent: Letter dated 7-29-02:
“Pain management programs are structured to provide coordinated, goal-oriented, interdisciplinary team services to reduce pain, improve functioning and decrease the dependence on the health care system. (Carrier) reimburses these services at a fair and reasonable rate of \$125 per hour for an accredited provider and \$100 per hour for a non-CARF accredited facility. This is the result of extensive review of all identifiable Chronic Pain Management Programs across the state of Texas. All contacted providers found our consistent reimbursement of \$100 for Non-CARF accredited providers to be acceptable.... Documentation submitted indicates that our rate of \$100 per hour is more than fair and reasonable as required by TWCC Guidelines. While we realize that the use of codes with no assigned MAR is necessary, they should not be used as an opportunity for excessive billing...”.

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are 7-2-01, 7-3-01, 7-5-01, 7-9-01 and 7-10-01.
2. The carrier denied the billed services as reflected on the EOBs as, “F – REDUCTION ACCORDING TO MEDICAL FEE GUIDELINES; M – Z436 – (F) CHRONIC PAIN MANAGEMENT; Z560 THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE OR USUAL AND CUSTOMARY VALUES AS ESTABLISHED BY (Audit Company)”.
3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MARS	REFERENCE	RATIONALE:
7- 2-01	97799-CP	\$ 540.00	\$300.00	F, M Z436, F Z560	No MAR	133.307 (j) (2) CPT Descriptor	<p>The Carrier has denied the disputed dates of service as, “F – REDUCTION ACCORDING TO MEDICAL FEE GUIDELINES; M – Z436 – (F) CHRONIC PAIN MANAGEMENT; Z560 THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE OR USUAL AND CUSTOMARY VALUES AS ESTABLISHED BY INGENIX”.</p> <p>The Provider has billed their Chronic Pain Program at \$180.00 per hour. The carrier has reimbursed at \$100.00 per hour for a Non CARF accredited facility.</p> <p>CPT Code 97799-CP does not have a MAR value and is not subject to a reduction based on usual and customary fees. Rather, CPT Code 97799-CP is reimbursed based on fair and reasonable.</p> <p>The carrier has raised the denial of fair and reasonable in their position statement, however, a denial based on fair and reasonable was not noted as a denial prior to the filing of the dispute. TWCC Rule 133.307 (j) (2) states, “The response shall address only those denial reasons presented to the requestor prior to the date the request for medical dispute resolution was filed with the division and the other party. Responses shall not address new or additional denial reasons or defenses after the filing of an initial request. Any new denial reasons or defenses raised shall not be considered in the review.”</p> <p>The Provider is a Non-CARF accredited facility and subject to a 20% reduction in the hourly fee. Therefore, additional reimbursement is recommended in the amount of \$880.00. (The Provider has billed \$180.00 per hour - a 20% hourly reduction. 20 hours at \$144.00 per hour = \$2,880.00 - \$2,000.00 already paid leaves a balance of \$880.00.)</p>
7- 3-01	97799-CP	\$ 540.00	\$300.00	F, M Z436, F Z560			
7- 5-01	97799-CP	\$ 540.00	\$300.00	F, M Z436, F Z560			
7- 9-01	97799-CP	\$ 900.00	\$500.00	F, M Z436, F Z560			
7-10-01	97799-CP	\$1,080.00	\$600.00	F, M Z436, F Z560			
Totals		\$3,600.00	\$2,000.00				The Requestor is entitled to additional reimbursement in the amount of \$880.00 .

V. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit **\$880.00** plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 07th day of March 2003.

Lesia Lenart
Medical Dispute Resolution Officer
Medical Review Division

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